

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

5883

County Harford Co

(64)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 183Village or City Black Horse (No. \_\_\_\_\_, \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Ayres

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Oct 29, 1880  
(Month) (Day) (Year)

7 AGE 6.3 yrs. 5 mos. — ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) Employer

9 BIRTHPLACE (State or country) Maryland

PARENTS  
10 NAME OF FATHER John Ayres  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Elizabeth Purdue  
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Richardson Jr  
(Address) White Hall Md.

15 Filed June 30, 1914 J. P. Phillips  
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 28, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1914, to June 28, 1914,  
that I last saw him alive on June 26, 1914.

and that death occurred on the date stated above, at 2 P.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Hemorrhage(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 13 ds.Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) H. F. Bradley, M. D.June 28, 1914. (Address) Fairview Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

McKendry Cemetery July 1, 1914

20 UNDERTAKER ADDRESS

S. M. Kirkwood White Hall Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

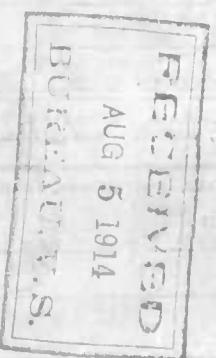
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



5884

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 184

1 PLACE OF DEATH  
County HarfordVillage or City Whiteford (No. 11)

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME "Infant" Beard

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, DIVORCED (Write the word)6 DATE OF BIRTH June 14, 1914  
(Month) (Day) (Year)7 AGE Still Born If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?8 OCCUPATION (a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Whiteford Md10 NAME OF FATHER Harry Beard11 BIRTHPLACE OF FATHER (State or country) Md12 MAIDEN NAME OF MOTHER Hannah Norris13 BIRTHPLACE OF MOTHER (State or country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Beard(Address) Street Md15 Filed June 15, 1914 for Wm Beard REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 14, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Strangulation of Umbilical Cord in birth  
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) P. Warren Pansoy, M. D.  
June 14, 1914 (Address) Della Pa

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Michaels. Care of Dr. C. June 16, 1914 DATE OF BURIAL20 UNDERTAKER Harry Beard ADDRESS Street Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

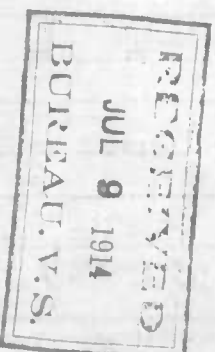
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5885  
County Harford  
Village or City Street Pa (No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)  
2 FULL NAME William Cantler  
Registration Dist. No. 184  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married  
6 DATE OF BIRTH \_\_\_\_\_, 1874 (Month) (Day) (Year)  
7 AGE 48 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?  
8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania  
PARENTS  
10 NAME OF FATHER Frank Cantler  
11 BIRTHPLACE OF FATHER (State or country) Maryland  
12 MAIDEN NAME OF MOTHER Mary Ross  
13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Walter Cantler  
(Address) Delton Pa

15 Filed June 22, 1914 Jas. W. McNabb  
REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 21, 1914 (Month) (Day) (Year)  
17 I HEREBY CERTIFY, That I attended deceased from June 21, 1914, to \_\_\_\_\_, 191\_\_\_\_, that I last saw him alive on June 21, 1914, and that death occurred on the date stated above, at 11:45 P.m., The CAUSE OF DEATH\* was as follows:  
Fracture of Skull  
caused by being thrown out  
of wagon.  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory \_\_\_\_\_  
Secondary \_\_\_\_\_  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) Charles W. Gannon, M. D.  
June 22, 1914 (Address) Street Pa ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted, If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Tabernacle Cemetery Pa DATE OF BURIAL June 23, 191\_\_\_\_  
20 UNDERTAKER Grafton Devoe ADDRESS Ind Pylesville

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

*oma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUL 9 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| 1 PLACE OF DEATH   |  |   | 5886              |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |                                     |
|--|--|---|-------------------|--|---|-------------------------------------|
| County <u>Harford</u>  |  |   |                   |  | Registration Dist. No. <u>187</u>         |                                     |
| Village or City <u>Harbithe</u>  |  |   | (No. <u>150</u> ) |  | St.; Ward                                 |                                     |
| 2 FULL NAME <u>Pearl Christ</u>  |  |   |                   |  |   |                                     |
| PERSONAL AND STATISTICAL PARTICULARS   |  |   |                   |  |   |                                     |
| 3 SEX<br><u>Female</u>   | 4 COLOR OR RACE<br><u>Black</u>                            | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Infant</u> |                   |  |   |                                     |
| 6 DATE OF BIRTH <u>Mar 15, 1914</u><br>(Month) (Day) (Year)  |  |   |                   |  |   |                                     |
| 7 AGE <u>3 yrs. 7 mos. 7 ds.</u> If LESS than 1 day, hrs. OR min. ?  |  |   |                   |  |   |                                     |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Infant</u><br>(b) General nature of industry, business, or establishment in which employed (or employer)  |  |   |                   |  |   |                                     |
| 9 BIRTHPLACE (State or country) <u>Harford Co Md</u>   |  |   |                   |  |   |                                     |
| PARENTS  | 10 NAME OF FATHER <u>Chas Christ</u>                       |   |                   |  |   |                                     |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> |   |                   |  |   |                                     |
|  | 12 MAIDEN NAME OF MOTHER <u>Francis Welchman</u>           |   |                   |  |   |                                     |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>   |  |   |                   |  |   |                                     |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>Informant: <u>Chas Christ</u><br><u>Harbithe Md</u><br>(Address)   |  |   |                   |  |   |                                     |
| 15 <u>June 25, 1914</u> <u>Local</u> REGISTRAR   |  |   |                   |  |   |                                     |
| MEDICAL CERTIFICATE OF DEATH   |  |   |                   |  |   |                                     |
| 16 DATE OF DEATH <u>June 24, 1914</u><br>(Month) (Day) (Year)  |  |   |                   |  |   |                                     |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Mar 15, 1914</u> , to <u>June 24, 1914</u> , that I last saw him alive on <u>May 10, 1914</u> , and that death occurred on the date stated above, at <u>5:30 a.m.</u> , The CAUSE OF DEATH* was as follows:<br><u>Hydrocephalus</u><br>(Duration) <u>3</u> yrs. <u>7</u> mos. <u>7</u> ds. |  |   |                   |  |   |                                     |
| Contributory (Secondary) <u>Chas Christ</u> (Duration) <u>3</u> yrs. <u>7</u> mos. <u>7</u> ds.  |  |   |                   |  |   |                                     |
| (Signed) <u>Chas Christ</u> , M. D.<br><u>June 24, 1914</u> (Address) <u>Edgewood Rd</u>   |  |   |                   |  |   |                                     |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |  |   |                   |  |   |                                     |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death <u>3</u> yrs. <u>7</u> mos. <u>7</u> ds. In the State <u>3</u> yrs. <u>7</u> mos. <u>7</u> ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence  |  |   |                   |  |   |                                     |
| 19 PLACE OF BURIAL OR REMOVAL <u>Magnolia Cemetery</u>   |  |   |                   |  |   | DATE OF BURIAL <u>June 25, 1914</u> |
| 20 UNDERTAKER <u>Howard K Mcbride</u>  |  |   |                   |  |   | ADDRESS <u>Abingdon</u>             |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.   |  |   |                   |  |   |                                     |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Harford 5887 (150)  
Village or City Harre De Grace (No. \_\_\_\_\_) St.; \_\_\_\_\_ Ward) Registration Dist. No. 185  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]  
2 FULL NAME Baby, Gulton

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant  
(Write the word)

6 DATE OF BIRTH June 15, 1914  
(Month) (Day) (Year)

7 AGE 1 day, \_\_\_\_\_ hrs. 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. OR \_\_\_\_\_ min. ?  
If LESS than 1 day, \_\_\_\_\_ hrs.

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Infant  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Harre De Grace

10 NAME OF FATHER Willie C. Gulton  
11 BIRTHPLACE OF FATHER (State or country) Harford Co. Md.  
12 MAIDEN NAME OF MOTHER Alice Boyce  
13 BIRTHPLACE OF MOTHER (State or country) Omaha Neb.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Willie C. Gulton  
(Address) Harre De Grace

15 Filed James H. Bay 1914 James H. Bay REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June 17th, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 15, 1914, to June 17, 1914.

that I last saw him alive on June 17, 1914.

and that death occurred on the date stated above, at 7 p. m.

The CAUSE OF DEATH\* was as follows:

Hydrocephalus  
(Duration) 1 yrs. 2 mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) James H. Bay M. D.  
June 18th, 1914 (Address) Harre De Grace

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Angel Hill Cemetery June 18, 1914

20 UNDERTAKER ADDRESS

J. A. Cunningham Holmes

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

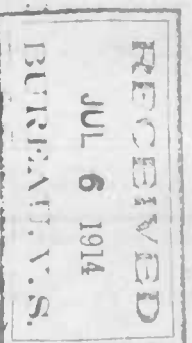
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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## 1 PLACE OF DEATH

5888

County

*Baltimore*

Village or City

*Norrisville*

(No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

Registration Dist. No.

*183*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

*James Alexander Gardaw*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

*Married*

6 DATE OF BIRTH

*March**27**1887*

(Month)

(Day)

(Year)

7 AGE

*77*

yrs.

*3*

mos.

*2*

ds.

If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

*Md =*

## PARENTS

10 NAME OF FATHER

*Andy Gardaw*

11 BIRTHPLACE OF FATHER

(State or country)

*Md =*

12 MAIDEN NAME OF MOTHER

*England*

13 BIRTHPLACE OF MOTHER

(State or country)

*Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Mrs. Nolia Harrison*

(Address)

*Norrisville*

15

Filed

*July 31**1914**J. T. Turner*

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*June**29**1914*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

*June 26, 1914, to June 29, 1914,*that I last saw him alive on *June 29, 1914*and that death occurred on the date stated above, at *3 P. m.*

The CAUSE OF DEATH\* was as follows:

*Left Hemiplegia*

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributors

*Arterio-sclerosis*

Secondary

Causality

(Duration) *6* yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

*W. H. Harrison*

M. D.

*June 30, 1914* (Address) *New Park Pa.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

In the

State

\_\_\_\_\_ yrs.

\_\_\_\_\_ mos.

\_\_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

*Norrisville*

DATE OF BURIAL

*July 3, 1914*

20 UNDERTAKER

*H. R. Webb*

ADDRESS

*Farm 100 Pa*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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| 1 PLACE OF DEATH  |                 | 5889   |  | STATE OF MARYLAND   |  |
|---|-----------------|--|--|---|--|
| County  |                 | Harford  |  | CERTIFICATE OF DEATH  |  |
| Village or City   |                 | Shanar Run No.   |  | Registered No. 182  |  |
| 2 FULL NAME   |                 | Jno. D. Gilbert  |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| PERSONAL AND STATISTICAL PARTICULARS  |                 |  |  |   |  |
| 3 SEX   | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |  |   |  |
| Male  | white           | Single   |  |   |  |
| 6 DATE OF BIRTH   |                 | 7 AGE  |  |   |  |
| June 24, 1914   |                 | If LESS than 1 day, hrs. 4 ds. OR min. ?                 |  |   |  |
| 8 OCCUPATION  |                 | 9 BIRTHPLACE (State or country)                          |  |   |  |
| (a) Trade, profession, or particular kind of work   |                 | Harford Co.  |  |   |  |
| (b) General nature of industry, business, or establishment in which employed (or employer)  |                 | Infant   |  |   |  |
| 10 NAME OF FATHER   |                 | 11 BIRTHPLACE OF FATHER (State or country)               |  |   |  |
| Wm. Gilbert   |                 | Harford Co.  |  |   |  |
| 12 MAIDEN NAME OF MOTHER  |                 | 13 BIRTHPLACE OF MOTHER (State or country)               |  |   |  |
| Adah Bull   |                 | Harford Co.  |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  |                 |  |  |   |  |
| (Informant) Wm. Gilbert   |                 |  |  |   |  |
| (Address) Bel Air, R. D.  |                 |  |  |   |  |
| 15 June 28, 1914  |                 |  |  |   |  |
| 16 DATE OF DEATH June 28, 1914 (Month) (Day) (Year)   |                 |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from June 24, 1914, to June 28, 1914, that I last saw him alive on June 26, 1914, and that death occurred on the date stated above, at 4:30 A. M. The CAUSE OF DEATH* was as follows: |                 |  |  |   |  |
| General Weakness from Birth (Duration) — yrs. — mos. — ds.  |                 |  |  |   |  |
| Contributory (Secondary)  |                 |  |  |   |  |
| (Signed) F. Lee Hughes, M. D. June 28, 1914 (Address) Bel Air   |                 |  |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |                 |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)   |                 |  |  |   |  |
| At place of death yrs. mos. ds. In the State yrs. mos. ds.  |                 |  |  |   |  |
| Where was disease contracted, If not at place of death?   |                 |  |  |   |  |
| Former or usual residence   |                 |  |  |   |  |
| 19 PLACE OF BURIAL OR REMOVAL   |                 |  |  | DATE OF BURIAL  |  |
| Thomas Ann Cemetery   |                 |  |  | June 29, 1914   |  |
| 20 UNDERTAKER   |                 |  |  | ADDRESS   |  |
| D. Dean & Son   |                 |  |  | Bel Air Md.   |  |
| REGISTRAR   |                 |  |  |   |  |

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*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|   |   |   |              |   |                                   |
|---|---|---|--------------|---|-----------------------------------|
| 1 PLACE OF DEATH<br>County <u>Bayford</u>   |   | 5890  | (176)        | STATE OF MARYLAND<br>CERTIFICATE OF DEATH |                                   |
| Village or City <u>Swan Creek</u>   |   | (No. <u>—</u> )   | St. <u>—</u> | Ward <u>—</u>                             | Registration Dist. No. <u>181</u> |
| 2 FULL NAME <u>William Hemore</u>   |   |   |              |   |                                   |
| PERSONAL AND STATISTICAL PARTICULARS  |   |   |              |   |                                   |
| 3 SEX<br><u>Male</u>  | 4 COLOR OR RACE<br><u>Black</u>                               | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Single</u> |              |   |                                   |
| 6 DATE OF BIRTH <u>Unknown</u><br>(Month) (Day) (Year)  |   |   |              |   |                                   |
| 7 AGE <u>abt. 41</u> yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?   |   |   |              |   |                                   |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work. <u>Labor</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>  |   |   |              |   |                                   |
| 9 BIRTHPLACE (State or country) <u>Bayford</u>  |   |   |              |   |                                   |
| PARENTS   | 10 NAME OF FATHER <u>Sidney Hemore</u>                        |   |              |   |                                   |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Bayford Co.</u> |   |              |   |                                   |
|   | 12 MAIDEN NAME OF MOTHER <u>Rosie Lee</u>                     |   |              |   |                                   |
|   | 13 BIRTHPLACE OF MOTHER (State or country) <u>Bayford Co.</u> |   |              |   |                                   |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Mr John Hemore</u><br>(Address) <u>Hoare de Grace</u>  |   |   |              |   |                                   |
| 15 Filed <u>June 26</u> , 191 <u>4</u> <u>Orin C. Muter</u> REGISTRAR   |   |   |              |   |                                   |
| MEDICAL CERTIFICATE OF DEATH  |   |   |              |   |                                   |
| 16 DATE OF DEATH <u>June 25<sup>th</sup></u> , 191 <u>4</u><br>(Month) (Day) (Year)   |   |   |              |   |                                   |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>June 25<sup>th</sup></u> , 191 <u>4</u> , to <u>June 25<sup>th</sup></u> , 191 <u>4</u> ,<br>that I last saw him alive on <u>June 25<sup>th</sup></u> , 191 <u>4</u> ,<br>and that death occurred on the date stated above, at <u>3 P.</u> m.<br>The CAUSE OF DEATH* was as follows:<br><u>Broken neck due to being dragged by a mule</u><br>(Duration) — yrs. — mos. — ds. |   |   |              |   |                                   |
| Contributory<br>Secondary<br>(Duration) — yrs. — mos. — ds.   |   |   |              |   |                                   |
| (Signed) <u>F. V. Steiner</u> , M. D.<br><u>June 25</u> , 191 <u>4</u> . (Address) <u>Hoare de Grace Md</u>   |   |   |              |   |                                   |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.   |   |   |              |   |                                   |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence.  |   |   |              |   |                                   |
| 19 PLACE OF BURIAL OR REMOVAL <u>St. John's Cemetery</u> DATE OF BURIAL <u>June 27</u> , 191 <u>4</u>   |   |   |              |   |                                   |
| 20 UNDERTAKER <u>J. A. Cunningham</u> ADDRESS <u>14 de Grace</u>  |   |   |              |   |                                   |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

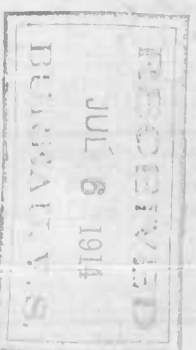
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

|   |                            |   |                              |                            |  |
|---|----------------------------|---|------------------------------|----------------------------|--|
| 1 PLACE OF DEATH<br>Harford   |                            | 5891  |                              | STATE OF MARYLAND          |  |
| County  |                            | (179)   |                              | CERTIFICATE OF DEATH       |  |
| Village or City<br>Abingdon   |                            | (No. _____)   |                              | Registration Dist. No. 180 |  |
| 2 FULL NAME<br>James Abram Howard   |                            | (St.; _____)  |                              | Ward) _____                |  |
| [If death occurred in a hospital or institution, give its NAME instead of street and number.] |                            |   |                              |                            |  |
| PERSONAL AND STATISTICAL PARTICULARS  |                            |   | MEDICAL CERTIFICATE OF DEATH |                            |  |
| 3 SEX<br>male   | 4 COLOR OR RACE<br>colored | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) married   |                              |                            |  |
| 6 DATE OF BIRTH<br>Sept 15, 1863  |                            | 16 DATE OF DEATH<br>June 8, 1914  |                              |                            |  |
| (Month) (Day) (Year)  |                            | (Month) (Day) (Year)  |                              |                            |  |
| 7 AGE<br>30 yrs. 8 mos. 25 ds.  |                            | 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,   |                              |                            |  |
| If LESS than 1 day, ____ hrs. OR ____ min. ?  |                            | that I last saw him alive on _____, 191____,  |                              |                            |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work<br>Rail Road Laborer        |                            | and that death occurred on the date stated above, at _____ m.   |                              |                            |  |
| (b) General nature of industry, business, or establishment in which employed (or employer)    |                            | The CAUSE OF DEATH* was as follows:   |                              |                            |  |
| 9 BIRTHPLACE<br>(State or country) Maryland   |                            | Contributory (Secondary) _____  |                              |                            |  |
| 10 NAME OF FATHER<br>Joseph Howard  |                            | (Duration) _____ yrs. _____ mos. _____ ds.  |                              |                            |  |
| 11 BIRTHPLACE OF FATHER<br>(State or country) Maryland  |                            | (Signed) _____ M. D.  |                              |                            |  |
| 12 MAIDEN NAME OF MOTHER<br>Cecilia Anderson  |                            | June 9, 1914 (Address) Edgewood Md  |                              |                            |  |
| 13 BIRTHPLACE OF MOTHER<br>(State or country) Maryland  |                            | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. |                              |                            |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>Informant) Amanda Howard                  |                            | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)   |                              |                            |  |
| (Address) Abingdon  |                            | At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.  |                              |                            |  |
| 15 Filed 4/11, 1914   |                            | Where was disease contracted, if not at place of death? _____   |                              |                            |  |
| L. B. C. REGISTRAR  |                            | Former or usual residence _____   |                              |                            |  |
| 19 PLACE OF BURIAL OR REMOVAL<br>John Wesley Cemetery   |                            | DATE OF BURIAL<br>June 11, 1914   |                              |                            |  |
| 20 UNDERTAKER<br>Howard K. McElmura   |                            | ADDRESS<br>Abingdon   |                              |                            |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **5892**  
County **Harford**

Village or City **Harre de Grace** (No. **50**)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. **185**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME **Mary A. Jones**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED **Widow**  
(Write the word)

6 DATE OF BIRTH **March 10, 1846**  
(Month) (Day) (Year)

7 AGE **68 yrs. 2 mos. 29 ds.** If LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work **House work**  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) **Cecil Co., Md.**

PARENTS  
10 NAME OF FATHER **Samuel B. Rearing**  
11 BIRTHPLACE OF FATHER (State or country) **Harre de Grace**  
12 MAIDEN NAME OF MOTHER **Emily Bamer**  
13 BIRTHPLACE OF MOTHER (State or country) **Cecil Co., Md.**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) **Samuel Jones**

(Address) **Harre de Grace Md.**

15 Filed **June 9, 1914** **J. H. Bay**  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **June 8, 1914**  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **June 2, 1914** to **June 8, 1914**

that I last saw her alive on **June 7, 1914**

and that death occurred on the date stated above, at **June 8, 1914** m.

The CAUSE OF DEATH\* was as follows:

**Diabetes Mellitus**

(Duration) **5** yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.

(Signed) **J. R. Hopkins**, M. D.  
**June 8, 1914** (Address) **Harre de Grace**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. in the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL **Angel Hill Cemetery** DATE OF BURIAL **June 10, 1914**

20 UNDERTAKER **J. A. Cunningham** ADDRESS **Harre de Grace**

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

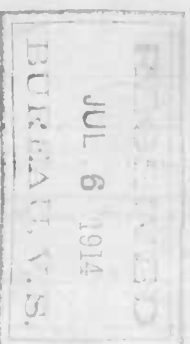
[Approved by U. S. Census and American Public Health Association.]

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*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1 PLACE OF DEATH<br>County <u>Harford</u>  |  | 5893<br>(118)  |  | STATE OF MARYLAND<br>CERTIFICATE OF DEATH   |  |
| Village or City <u>Harrods Grace</u> (No. _____)   |  | Registration Dist. No. <u>185</u>  |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.] |  |
| 2 FULL NAME <u>John B. Kenly</u>   |  |  |  |   |  |
| PERSONAL AND STATISTICAL PARTICULARS   |  |  |  |   |  |
| 3 SEX<br><u>Male</u>   | 4 COLOR OR RACE<br><u>White</u>                              | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <u>Married</u> |  |   |  |
| 6 DATE OF BIRTH <u>July 2, 1849</u><br>(Month) (Day) (Year)  |  |  |  |   |  |
| 7 AGE <u>65</u> yrs. <u>9</u> mos. <u>29</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?  |  |  |  |   |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work <u>Carpenter</u><br>(b) General nature of industry, business, or establishment in which employed (or employer) _____   |  |  |  |   |  |
| 9 BIRTHPLACE (State or country) <u>Harrods Grace</u>   |  |  |  |   |  |
| PARENTS  | 10 NAME OF FATHER <u>Danial Kenly</u>                        |  |  |   |  |
|  | 11 BIRTHPLACE OF FATHER (State or country) <u>Harford Co</u> |  |  |   |  |
|  | 12 MAIDEN NAME OF MOTHER <u>Jonnie Blaney</u>                |  |  |   |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Harford Co</u>   |  |  |  |   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>J. T. C. Kenly</u><br>(Address) <u>Harrods Grace</u>  |  |  |  |   |  |
| 15 Filed <u>June 3, 1914</u> <u>J. H. Bay</u> REGISTRAR  |  |  |  |   |  |
| MEDICAL CERTIFICATE OF DEATH   |  |  |  |   |  |
| 16 DATE OF DEATH <u>June 1st</u> , 191 <u>4</u><br>(Month) (Day) (Year)  |  |  |  |   |  |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>May 28</u> , 191 <u>4</u> , to <u>June 1st</u> , 191 <u>4</u> , that I last saw him alive on <u>June 1st</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>10 P.</u> m.   |  |  |  |   |  |
| The CAUSE OF DEATH* was as follows:<br><u>Abscess in right elbow, region of staphylococcal infection</u><br>(Duration) ____ yrs. ____ mos. <u>6</u> ds.<br>Contributory <u>Wound</u> Secondary <u>Chronic</u><br>(Duration) <u>Op</u> yrs. <u>8</u> mos. ____ ds.<br>(Signed) <u>A. C. Brothers</u> , M. D.<br><u>June 2</u> , 191 <u>4</u> . (Address) <u>Harrods Grace</u> |  |  |  |   |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |  |  |  |   |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.<br>Where was disease contracted, If not at place of death?<br>Former or usual residence _____  |  |  |  |   |  |
| 19 PLACE OF BURIAL OR-REMOVAL<br><u>Angel Hill Cemetery</u>  |  |  |  | DATE OF BURIAL<br><u>June 4, 1914</u>   |  |
| 20 UNDERTAKER<br><u>J. A. Birmingham</u>   |  |  |  | ADDRESS<br><u>Harrods Grace</u>   |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

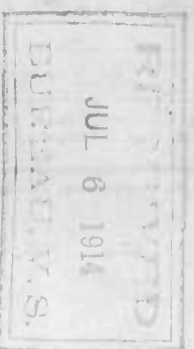
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully filled in. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

5894

(81)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185-

County HarfordVillage or City Harrods Grace No. \_\_\_\_\_

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Annie Lisby

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Unknown, 1 \_\_\_\_\_  
(Month) (Day) (Year)

7 AGE About 56 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work House work  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Harford

10 NAME OF FATHER Charles Jones

11 BIRTHPLACE OF FATHER (State or country) Harford Co.

12 MAIDEN NAME OF MOTHER Margaret Richardson

13 BIRTHPLACE OF MOTHER (State or country) Harford Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Lisby(Address) Harrods Grace R.T.D.

15 June 22nd, 1914 James H. Bay  
Filed \_\_\_\_\_ REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 20th, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1912, to June 20th, 1914.

that I last saw her alive on June 20th, 1914.

and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH\* was as follows:

Cerebro-sclerosis

(Duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

Myocarditis

(Signed) L. H. Steiner, M. D.

June 20, 1914. (Address) Harrods Grace

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Gravelly Hill DATE OF BURIAL June 23, 1914

20 UNDERTAKER J. A. Cunningham ADDRESS Harrods Grace

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

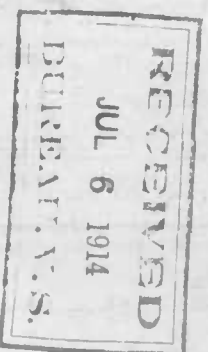
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not satisfactorily employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 5895

County HagerstonVillage or City Benjamin (No. 154) St.; Ward)

2 FULL NAME

Wilhelmina LieskeSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 181

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Feb 12, 1881  
(Month) (Day) (Year)

7 AGE 83 yrs. 3 mos. 22 ds. IT LESS THAN 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Carrie Hirsing(Address) Benjamin and

15

June 5, 1914 Oscar E. Hirsch  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 4, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1914, to June 4, 1914.

that I last saw him alive on June 4, 1914.

and that death occurred on the date stated above, at Benjamin m.

The CAUSE OF DEATH\* was as follows:

Old age -  
(no definite disease)

(Duration)        yrs.        mos.        ds.

Contributory (Secondary)

(Duration)        yrs.        mos.        ds.

(Signed) Dr. C. C. O'Leary, M. D.  
June 5, 1914 (Address) Benjamin Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds.

Where was disease contracted, if not at place of death?       

Former or usual residence       

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sutherland Cemetery June 7, 1914

20 UNDERTAKER ADDRESS

G. O. Stouffer Benjamin

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

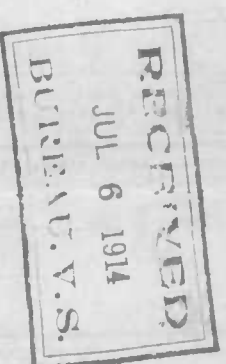
# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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5896

(61)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 181

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 1 PLACE OF DEATH

County

Harford

Village or City

Carsins

(No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2 FULL NAME

Clarice Morgan

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Single

## 6 DATE OF BIRTH

Oct. 5, 1912  
(Month) (Day) (Year)

## 7 AGE

1 yrs. 8 mos. 17 ds. OR LESS than 1 day. hrs. OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Carsins, Md

## PARENTS

## 10 NAME OF FATHER

Charley B. Morgan

11 BIRTHPLACE OF FATHER  
(State or country)

Harford Co Md

## 12 MAIDEN NAME OF MOTHER

Clara O. Morgan

13 BIRTHPLACE OF MOTHER  
(State or country)

Harford Co Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charley B. Morgan

(Address)

Chesden Md (R.D.)

## 15

Filed

June 22, 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

June 22, 1914  
(Month) (Day) (Year)

## 17 I HEREBY CERTIFY, That I attended deceased from

June 10, 1914, to June 22, 1914

that I last saw him alive on June 20, 1914

and that death occurred on the date stated above, at 9 A. m.

The CAUSE OF DEATH\* was as follows:

Spinal Meningitis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
(Secondary)

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed)

C. S. White, M. D.

June 22, 1914 (Address) Chesden Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Smith Chapel June 24, 1914

## 20 UNDERTAKER

## ADDRESS

Henry Tarring Chesden Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

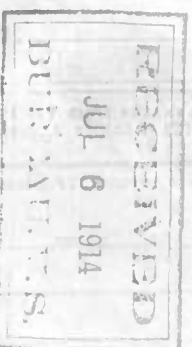
Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. It is impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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5897

## 1 PLACE OF DEATH

County

*Harpur*

(151)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

185-

Village or City

*Harold's Cove*

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

*Not named**Pico*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Female*

4 COLOR OR RACE

*Black*5 SINGLE,  
MARRIED,  
WIDDED,  
OR DIVORCED  
(Write the word)*Single*

6 DATE OF BIRTH

*June 26, 1914*  
(Month) (Day) (Year)

7 AGE

It LESS than  
1 day, 6 hrs.

yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

*None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

*Harold's Cove Md*

PARENTS

10 NAME OF FATHER

*Not known*11 BIRTHPLACE OF FATHER  
(State or country)*" "*

12 MAIDEN NAME OF MOTHER

*Lizzie Pico*13 BIRTHPLACE OF MOTHER  
(State or country)*Harold's Cove Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

*Abraham Pico*

(Address)

*Harold's Cove Md*

16

Filed

*June 27th, 1914*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*June 27, 1914*  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
*June 26, 1914, to June 27, 1914,*that I last saw her alive on *June 26, 1914*and that death occurred on the date stated above, at *6 P.* m.

The CAUSE OF DEATH\* was as follows:

*Congenital weakness*  
(Duration) yrs. mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed)

*J. W. Steiner*

, M. D.

*June 27, 1914* (Address) *Harold's Cove Md*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*James Cemetery**June 27th, 1914*

20 UNDERTAKER

ADDRESS

*Parent**Harold's Cove*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

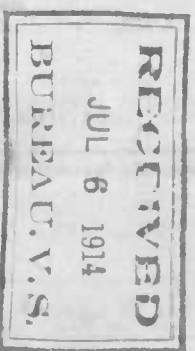
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras-mus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 5898  
County Harford

Village or City Heckington (No. 40)

2 FULL NAME Ann J. Scott

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 182

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
(Write the word)

6 DATE OF BIRTH Dec 25, 184  
(Month) (Day) (Year)

7 AGE 72 yrs. 5 mos. 21 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER John Morrey

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Mullen

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Mary Scott

(Address) Norwood Ave. Jones

15 Filed June 17, 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 11, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9<sup>th</sup> June 1914 for the first and only time the above date that I last saw h. 22 alive on June 22, 1914

and that death occurred on the date stated above, at 2 a m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of the Stomach  
had been operated on about  
a year ago  
about (Duration) two yrs. 0 mos. 0 ds.

Contributory  
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.  
(Signed) William P. Archer M. D.  
, 1914 (Address) Bethesda Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Ignace Cemetery June 17, 1914

20 UNDERTAKER ADDRESS

A. Dean & Son Bethesda Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

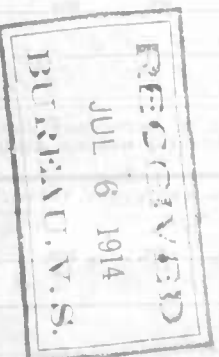
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH <u>6225</u>  |  | STATE OF MARYLAND  |  |
| County <u>Harford</u>   |  | CERTIFICATE OF DEATH   |  |
| Village or City <u>North Aberdeen</u> (No. <u>5</u> ), _____ St.; _____ Ward)   |  | Registration Dist. No. <u>181</u>  |  |
| 2 FULL NAME <u>Smith</u>  |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.]  |  |
| PERSONAL AND STATISTICAL PARTICULARS  |  |  |  |
| 3 SEX <u>Female</u>   | 4 COLOR OR RACE <u>White</u>                                   | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u><br>(Write the word)                      |  |
| 6 DATE OF BIRTH <u>June 20</u> , 191 <u>4</u><br>(Month) (Day) (Year)   |  |  |  |
| 7 AGE <u>Still born</u>   |  | If LESS than 1 day, _____ hrs. _____ min. ?<br>_____ yrs. _____ mos. _____ ds. OR _____ min. ? |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work _____<br>(b) General nature of industry, business, or establishment in which employed (or employer) _____             |  |  |  |
| 9 BIRTHPLACE (State or country) <u>Md</u>   |  |  |  |
| PARENTS   | 10 NAME OF FATHER <u>Wm. E. Smith</u>                          |  |  |
|   | 11 BIRTHPLACE OF FATHER (State or country) <u>Chicago</u>      |  |  |
|   | 12 MAIDEN NAME OF MOTHER <u>Helen L. [maiden name unknown]</u> |  |  |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Mich</u>  |  |  |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <u>Sadie R. Schofield</u><br>(Address) <u>Aberdeen Md</u>   |  |  |  |
| 15 Filed <u>Oct 5</u> , 191 <u>4</u> <u>Wm. E. Smith</u> REGISTRAR  |  |  |  |
| MEDICAL CERTIFICATE OF DEATH  |  |  |  |
| 16 DATE OF DEATH <u>June 20</u> , 191 <u>4</u><br>(Month) (Day) (Year)  |  |  |  |
| 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.   |  |  |  |
| that I last saw h. _____ alive on _____, 191____.   |  |  |  |
| and that death occurred on the date stated above, at _____ m.   |  |  |  |
| The CAUSE OF DEATH* was as follows: <u>Still Born</u>   |  |  |  |
| (Duration) _____ yrs. _____ mos. _____ ds.  |  |  |  |
| Contributory _____<br>Secondary _____   |  |  |  |
| (Signed) <u>Orion C. Michael, M.D.</u><br><u>Oct 7</u> , 191 <u>4</u> (Address) <u>Aberdeen Md</u>  |  |  |  |
| *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.                                     |  |  |  |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. |  |  |  |
| Where was disease contracted, If not at place of death? _____<br>Former or usual residence _____  |  |  |  |
| 19 PLACE OF BURIAL OR REMOVAL <u>Buried by a member of the family</u>   |  | DATE OF BURIAL <u>June 20</u> , 191 <u>4</u>   |  |
|   |  | ADDRESS _____  |  |

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECEIVED  
NOV 4 1914  
BUREAU. V. S.

RECEIVED  
OCT 8 1914  
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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5899

## 1 PLACE OF DEATH

County

Harford

Village or City

Harrede Grace

(No.

## 2 FULL NAME

Martha A Tobin

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

181

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7 AGE

abt. 58

yrs. — mos. — ds. OR min. ?

If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Harford Co. Md.

10 NAME OF FATHER

Edward King

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Alice A. Duffy

13 BIRTHPLACE OF MOTHER (State or country)

Harford Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William M. Tobin

(Address)

Harrede Grace R. D.

15

Filed June 15, 1914

G. B. C. Registrar

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 14, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1914, to June 13, 1914,

that I last saw her alive on June 11, 1914.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

Senile Debility

(Duration) yrs. 12 mos. ds.

Contributory (Secondary)

(Signed) J. L. Hopkins, M. D.  
June 14, 1914 (Address) Harrede Grace

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marvin Cemetery June 16, 1914

20 UNDERTAKER

ADDRESS

J. A. Cunningham, 1014 E. Harrede Grace

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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RECORDED

JUL 6 1914

RECEIVED U. S.

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1 PLACE OF DEATH  
County Harford  
Village or City Harre de Grace (No. 5900)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emma E. Ward

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH June 4, 1872  
(Month) (Day) (Year)

7 AGE 42 yrs. 23 ds. OR 1 day, 23 hrs. 42 min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work House work  
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country)  Cecil Co.

PARENTS  
10 NAME OF FATHER James L. Dinnie  
11 BIRTHPLACE OF FATHER (State or country) Cecil Co.  
12 MAIDEN NAME OF MOTHER Mollie Janney  
13 BIRTHPLACE OF MOTHER (State or country) Cecil Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rose Ward  
(Address) Harre de Grace

15 Filed June 27, 1914 J. H. Bay  
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 27, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April, 1914, to June 26, 1914.

that I last saw her alive on June 26, 1914.

and that death occurred on the date stated above, at 9 9 m.

The CAUSE OF DEATH\* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. — mos. — ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.  
(Signed) R. W. Smith, M. D.  
June 27, 1914 (Address) Harre de Grace Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Arbony Cemetery DATE OF BURIAL June 29, 1914

20 UNDERTAKER Cecil Co. ADDRESS J. A. Primm, Harre de Grace

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

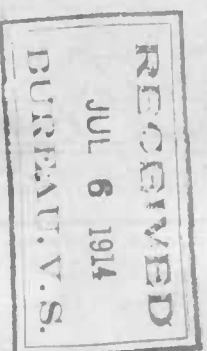
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

5901

154

STATE OF MARYLAND  
CERTIFICATE OF DEATH

County

Harford

Registration Dist. No.

184

Village or City

Buckley

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Webster

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro

5 SINGLE,

MARRIED,

WIDDED,

OR DIVORCED

(Write the word)

Widowed

6 DATE OF BIRTH

— — — — — 1 — — — — —  
(Month) (Day) (Year)

7 AGE

about 85 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Moses Webster

11 BIRTHPLACE OF FATHER  
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

do not know

13 BIRTHPLACE OF MOTHER  
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. Webster

(Address)

Buckley

15

Filed

June 9, 1914

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 8, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

—, 191—, to —, 191—,

that I last saw him alive on about Nov 15, 1913

and that death occurred on the date stated above, at 11-40 P.M.

The CAUSE OF DEATH\* was as follows:

did not attend deceased in his last illness and therefore can not ascribe the following condition yrs. 4 mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. E. Sallins, M. D.

June 9, 1914. (Address) 5 Lexington Dr.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rosanna Cem June 10, 1914

20 UNDERTAKER

ADDRESS

Herbert S. Bailey, Warlington, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V.B. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED  
JUL 9 1914  
BUREAU, U. S.

5902

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 1874

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## 1 PLACE OF DEATH

County

Harford

Village or City

Pylesville

(No. ....)

St; .....

Ward) .....

## 2 FULL NAME

Mary Ann Wilson

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female

## 4 COLOR OR RACE

White

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

## 6 DATE OF BIRTH

July 24, 1844  
(Month) (Day) (Year)

## 7 AGE

69 yrs. 10 mos. 20 ds.  
It LESS than  
1 day, .... hrs.  
OR .... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

House Wife

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)9 BIRTHPLACE  
(State or country)

Ind

## PARENTS

10 NAME OF  
FATHER

James McElster

11 BIRTHPLACE  
OF FATHER  
(State or country)

Ind.

12 MAIDEN NAME  
OF MOTHER

Ann Tall

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Ind

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant)

Samuel Wilson

(Address)

Pylesville Ind

## 15

Filed

June 16, 1914

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

June 14, 1914  
(Month) (Day) (Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

Mar. 1, 1914, to June 14, 1914.

that I last saw her alive on June 14, 1914.

and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH\* was as follows:

Paralysis of the muscles  
of the Throat.

(Duration) 1 yrs. 4 mos. 6 ds.

Contributory  
(Secondary)Exhaustion + Starvation  
became could not swallow any food.

(Duration) yrs. mos. ds.

(Signed)

Charles W. Gammon

, M. D.

June 16, 1914

(Address) Street P. Ind.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDEN-  
TAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place

of death

yrs. .... mos. .... ds.

In the

State

yrs. .... mos. .... ds.

Where was disease contracted,  
If not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

## DATE OF BURIAL

Highland County

June 17, 1914

## 20 UNDERTAKER

## ADDRESS

Baltimore

DELAWARE

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 5903  
County Harford

Village or City Harred Grace (No. 151)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 185

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mildred E. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec. 29, 1913  
(Month) (Day) (Year)

7 AGE 5 yrs. 13 mos. 13 ds. It LESS than 1 day, .... hrs. OR .... min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer) C

9 BIRTHPLACE (State or country) Harred Grace

10 NAME OF FATHER William Wilson

11 BIRTHPLACE OF FATHER (State or country) Harred Grace

12 MAIDEN NAME OF MOTHER Alberta Wright

13 BIRTHPLACE OF MOTHER (State or country) Harred Grace

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) William Wilson (Address) Harred Grace

15 Filed June 14th, 1914 James B. Bay REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 11, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 9th 1914, to June 11th 1914.

that I last saw her alive on June 11th 1914.

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH\* was as follows:

Morassm due to  
broken stomach during  
all of life  
(Duration) .... yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) .... yrs. .... mos. .... ds.  
(Signed) R. W. Smith, M. D.  
June 13, 1914 (Address) Harred Grace

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, It not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Angel Hill Cemetery DATE OF BURIAL June 14, 1914

20 UNDERTAKER J. B. Cunningham ADDRESS Harred Grace

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

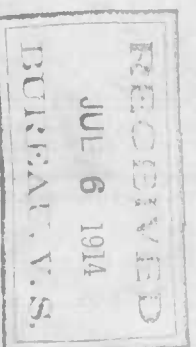
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|  |                                 |  |  |  |  |
|--|---------------------------------|--|--|--|--|
| 1 PLACE OF DEATH   |                                 | 5904   |  | STATE OF MARYLAND  |  |
| County <i>Harford</i>  |                                 | (159)  |  | CERTIFICATE OF DEATH   |  |
| Village or City <i>Harrede Grace</i>   |                                 | (No. _____)  |  | Registration Dist. No. <i>181</i>  |  |
| 2 FULL NAME <i>Mamie Wolf</i>  |                                 |  |  | [If death occurred in a hospital or institution, give its NAME instead of street and number.]  |  |
| PERSONAL AND STATISTICAL PARTICULARS   |                                 |  |  |  |  |
| 3 SEX<br><i>Female</i>   | 4 COLOR OR RACE<br><i>White</i> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED<br>(Write the word) <i>married</i>                       |  | 16 DATE OF DEATH <i>June 6th</i> , 191 <i>4</i><br>(Month) (Day) (Year)  |  |
| 6 DATE OF BIRTH <i>April 21</i> , 188 <i>9</i><br>(Month) (Day) (Year)   |                                 | 7 AGE <i>25</i> yrs. <i>1</i> mos. <i>15</i> ds.<br>If LESS than 1 day, .... hrs. OR .... min. ? |  | 17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw h. .... alive on _____, 191____, and that death occurred on the date stated above, at _____ m. |  |
| 8 OCCUPATION<br>(a) Trade, profession, or particular kind of work. <i>House wife</i><br>(b) General nature of industry, business, or establishment in which employed (or employer) _____ |                                 | 9 BIRTHPLACE (State or country) <i>Somerset Co Md</i>  |  | The CAUSE OF DEATH* was as follows:<br><i>Suicide, Suicidal, By Revolver shot in the head</i><br>(Duration) _____ yrs. _____ mos. _____ ds.  |  |
| 10 NAME OF FATHER <i>James Brittingham</i>   |                                 | 11 BIRTHPLACE OF FATHER (State or country) <i>Somerset Co Md</i>                                 |  | Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.  |  |
| 12 MAIDEN NAME OF MOTHER <i>Minnie Dryden</i>  |                                 | 13 BIRTHPLACE OF MOTHER (State or country) <i>Somerset Co Md</i>                                 |  | (Signed) <i>Joseph Humberger Crower</i> , M.D.<br>, 191____ (Address) <i>Harrede Grace Md.</i>   |  |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE<br>(Informant) <i>Albert Wolf</i><br>(Address) <i>Harrede Grace</i>   |                                 | 15 Filed <i>June 8</i> , 191 <i>4</i> <i>Onor. L. Michael</i><br>REGISTRAR                       |  | *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.  |  |
| 16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)<br>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.  |                                 | 17 PLACE OF BURIAL OR REMOVAL <i>Angel Hill Cemetery</i>   |  | DATE OF BURIAL <i>June 8</i> , 191 <i>4</i>  |  |
| 18 UNDERTAKER <i>J. G. Birmingham</i>  |                                 | 19 ADDRESS <i>Harrede Grace</i>  |  |  |  |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

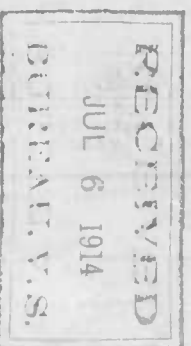
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

5905

64

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 183

County HarfordVillage or City White Hall (No. \_\_\_\_\_)

St.; \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Richard Wright

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 1 October, 1841  
(Month) (Day) (Year)

7 AGE 72 yrs. 8 mos. \_\_\_\_\_ ds. IT LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) White Hall, Md.

PARENTS  
10 NAME OF FATHER Caleb Wright  
11 BIRTHPLACE OF FATHER (State or country) White Hall, Md.  
12 MAIDEN NAME OF MOTHER Nancy Garrett  
13 BIRTHPLACE OF MOTHER (State or country) White Hall, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leslie F. Wright(Address) White Hall, Md.

15 June 29, 1914 J. P. Phillips  
Filed REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 28, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 20, 1914, to June 27, 1914.

that I last saw him alive on June 27, 1914.

and that death occurred on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH\* was as follows:

Haemiplegia(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 9 ds.Contributory (Secondary) Paralysis(Duration) \_\_\_\_\_ yrs. 3 mos. \_\_\_\_\_ ds.

(Signed) W. Millard Stirling, M. D.  
June 29, 1914 (Address) White Hall, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Dry Branch Cemetery DATE OF BURIAL June 30, 1914

20 UNDERTAKER S. M. Stirling ADDRESS White Hall, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesenteric*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mesenteric* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Transition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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